

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 4 1940

Registration District No. 217

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3016

State File No. 10881

Registrar's No. 29

1. PLACE OF DEATH:

(a) County Franklin
(b) City or town Washington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Francis Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 da (Specify whether
In this community 49
years, months or days)

3. (a) PRINT FULL NAME Josephine Summer
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Geo. J. Summer 6. (c) Age of husband 54 years
7. Birth date of deceased January 29 1891
(Month) (Day) (Year)

8. AGE: Years 49 Months 1 Days 5 If less than one day _____ hr. _____ min.

9. Birthplace Union Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation House work

11. Industry or business _____

MOTHER FATHER { 12. Name Frank J. Lauffer
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Christine Bauer
15. Birthplace Union Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Leonard J. Summer
(b) Address Beaufort, Missouri

17. (a) Beaufort (b) Date thereof 3/7/1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union, Missouri

18. (a) Signature of funeral director E. H. Williams
(b) Address Union Mo. 270

19. (a) Mar. 5-1940 (b) H. D. May
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Franklin
(c) City or town Beaufort
(If outside city or town limits, write "RURAL")
(d) Street No. Rural
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 4th 1940
year 1940 hour 9 minute 25 A.M.

21. I hereby certify that I attended the deceased from Feb. 27
1940 to Mar. 4, 1940
that I last saw him alive on Mar. 4, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Acute myocarditis Duration 2 days

Due to General diffuse peritonitis 5 days

Due to Acute obstructed appendicitis 5 days

Other conditions 12/1

Major findings: large, obstructed appendix
Of operations performed in 2 places
Of autopsy none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature R. R. Cutler (M. D. gastro)
Address Washington Mo Date signed 3-5-40

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed E. F. Olthmann

Licensed Embalmer No. 1686

P. O. Address Union Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.